Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: VISTA HOSPITAL OF DALLAS 4301 VISTA ROAD PASADENA TX 77504	MFDR Tracking #: M4-10-0416-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: LIBERTY INSURANCE CORP REP. BOX #: 28	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "With regard to the charges at issue in this dispute, there is no evidence presented by the Carrier that the prices billed were not Provider's usual and customary charges (which the Provider must bill under Division rules) or that the final price was not fair and reasonable. Therefore, the Carrier is required to reimburse Vista Hospital of Dallas $9,917.82 pursuant to the Outpatient Fee Guidelines, which will result in fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of $5,405.47. Therefore, the Carrier is required to reimburse Provider in the additional amount of $4,512.35, plus any and all applicable interest…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill
3. EOBs
4. Medical Reports
5. Total Amount Sought $4,512.35

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "..The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged; Our rational is as follows: Denied CPT 29805 59 (Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure) as documentation does not support level of service billed. A diagnostic scope is incidental to other surgical procedures per Medicare & AAAOS and per CPT guidelines and should not be billed unless performed as the only procedure performed. If any other code is used, it is not appropriate to report the diagnostic code, even if the diagnostic arthroscopy is followed by an open procedure. CPT 23420 (Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) denied as not documented in the op report as performed. The operative report documents repair of partial thickness tear rotator cuff only. According to the American Association of Orthopaedic Surgeons, if there is significant retraction with a large tear, extensive releases and mobilization may be required justifying the use of code 23420. If fascia or synthetic material is required, code 23420 also is appropriate. In this instance the appropriate code would have been CPT 23410 for and [sic] open acute tear and or 23412 for an open chronic tear; however, the provider did not bill either code. Liberty Mutual believes that Vista Hospital of Dallas has been appropriately reimbursed for services rendered to [injured worker] for the 09/19/2008 date of service…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
09/19/2008	CPT Codes 23430-59 & 23420	N/A	$4,512.35	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 11/14/2008:
   - 150, Z652 – Recommendation of payment has been based upon a procedure code which best describes services rendered;
   - B12, X129 – Procedure not documented in operative report;
   - 42, Z710 – The charge for this procedure exceeds the fee schedule allowance; and
   - 150 – X901 – Documentation does not support level of service billed.

   The Requestor only submitted the initial Explanation of Benefits.
2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No contract exists;
   (2) MAR can be established for these services; and

(3) Separate reimbursement for implantables was *NOT* requested by the requestor.

6. According to the Requestors' Table of Disputed Services the services in dispute are CPT codes 23430-59 and 23420. CPT Code 29805-59 was listed on the Table of Disputed Services with a negative balance of <$3,595.87>; as such, this code will not be reviewed.
7. The Respondents Position Summary discusses CPT Code 29805-59, stating that documentation does not support level of service billed and is incidental to other surgical procedures per Medicare & AAOS and per CPT guidelines and should not be billed unless performed as the only procedure performed. However, pursuant to §133.307(d)(2)(B) the response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party.
8. CPT Code 23430-59 is described as, "Tenodesis of long tendon of biceps." According to the operative report, this procedure was documented in the operative report; however, according to the CCI edits this code was billed on the same date of service as another procedure without an appropriate modifier. Typically services with the lower relative value should be reported with modifier 51. The standard Medicare system handles multiple surgery logic automatically without the presence of a 51 modifier; however, the Requestor has applied an incorrect modifier; therefore, the amount ordered is $0.00.
9. CPT Code 23420 is described as, "Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)." According to the Respondents' Position Summary, this code was denied "as "procedure not documented in the operative report." Review of the operative report reveals that, "There was noted to be a partial thickness tear of the rotator cuff extending over 50% of the thickness…", therefore, the documentation does not support the reconstruction of a complete shoulder (rotator) cuff. As a result, the amount order is $0.00

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

		May 6, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.